Interior Health

HOME & COMMUNITY CARE

SERVICE PLAN 2004-2007

Leading in the delivery of flexible and responsive services
that focus on the desire of clients for
Choice, Independence, and Dignity

Additional copies: Copies of this document are available on the Interior Health website: www.interiorhealth.ca

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EXECUTIVE SUMMARY

Since 2002-03, Interior Health (IH) has implemented significant changes to the service delivery system of Home and Community Care (HCC). The results from of this system redesign will only begin to emerge in 2004-05 and will not be fully understood until subsequent years. As we look forward for the purpose of identifying the next cycle of initiatives, we are predicating our plans on the following assumptions: (a) that demand for services will increase due to a growing aging population, (b) the resources required to meet the demand will not increase at the same rate, and (c) the changes we are making now are transitioning us to the next phase of significant redesign.

The Interior Health 2004-07 Home and Community Care Service Plan outlined in this document continues to be based on the British Columbia Ministry of Health strategic direction and the learnings and input from key stakeholders across Interior Health. The initiatives identified in this document are a reflection of our current knowledge of client needs and system challenges. In order to succeed, all of the initiatives will require leadership, strategy development, resources, and partnering relationships.

Interior Health is committed to achieving our HCC vision of "Leading in the delivery of flexible and responsive services that focus on the desire of clients for Choice, Independence and Dignity". The following HCC goals will guide our actions towards achieving this vision:

1. To ensure home and community care based services provide clients with the option of remaining as independent as possible in their own homes.
2. In partnership with BC Housing and other housing providers, create options for increasing the number of units and the range of housing environments into which personal and professional care can be provided.
3. To continue to alleviate system pressure.
4. To focus our residential services on clients with high and complex care needs.
5. To implement Population Health Promotion initiatives that support healthy aging and prevent deterioration of chronic conditions.
6. Development of the infrastructure necessary to support future service renewal.

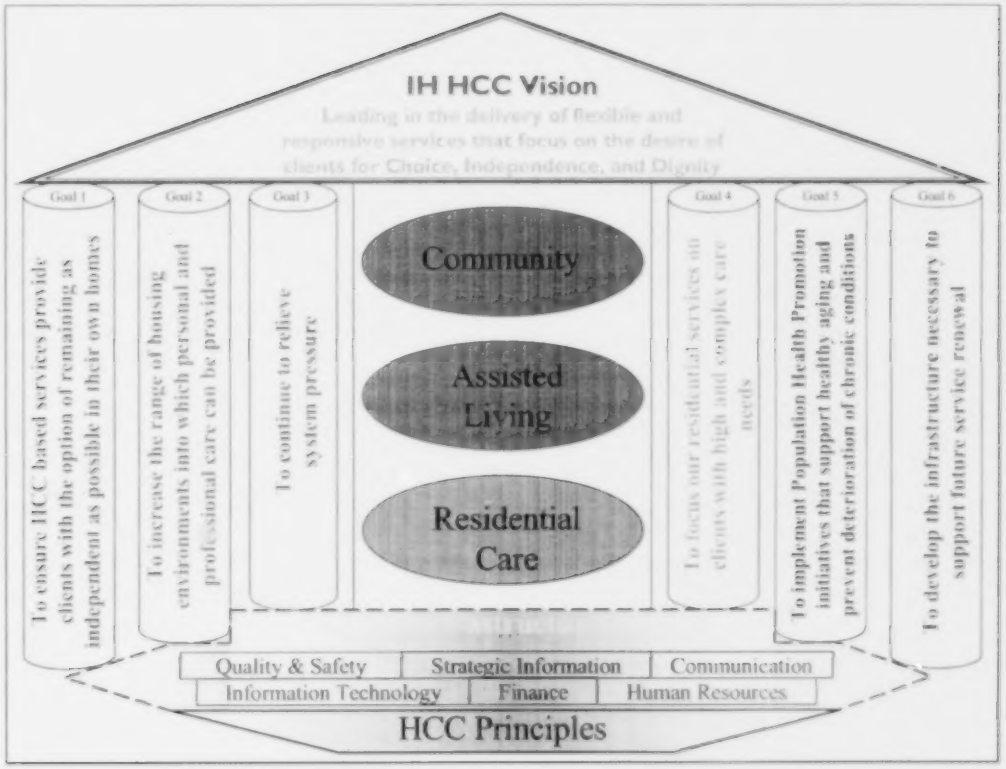
Diagram 1, provides a schematic of the dynamic interconnections between our principles, infrastructure, and goals that support the achievement the HCC vision.

Within each goal a number of priority initiatives have been identified, each with key milestones over the next 3 years. Key measures for monitoring and evaluating the achievement of these initiatives have been identified as well as the challenges. For many initiatives, linkages with other service plans within Interior Health as well as strategic provincial initiatives will be developed through collaborations and partnerships, contributing to the successful achievement of the overall goals.

Home and Community Care services are foundational to the sustainability of health care. Interior Health has approved this service plan as part of our commitment to ensuring sustainable services that effectively meet the needs of seniors and individuals with disability.

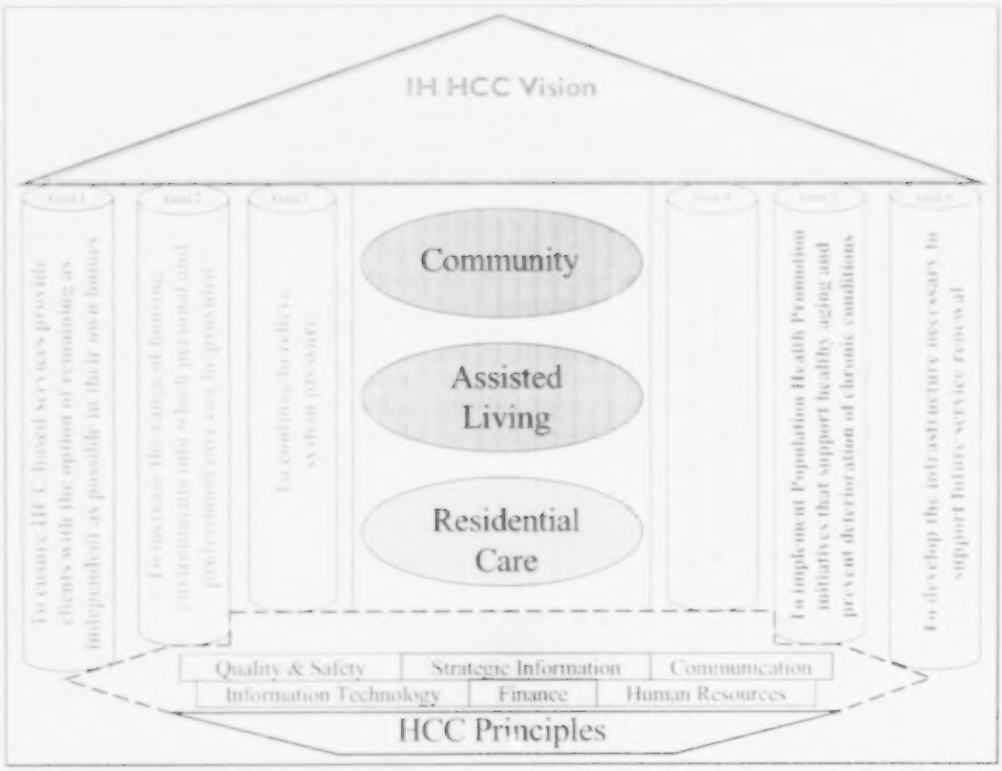
Leading in the delivery of flexible and responsive services that focus on the desire of CLIENTS for Choice, Independence, and Dignity

Diacram 1


IH HCC Vision
Leading in the delivery of flexible and responsive services that focus on the desire of clients for Choice, Independence, and Dignity
Goal 1
To ensure HCC based services provide clients with the option of remaining as independent as possible in their own homes
Goal 2
To increase the range of housing environments into which personal and professional care can be provided
Goal 3
To continue to relieve system pressure
Community
Assisted Living
Residential Care
Goal 4
To focus our residential services on clients with high and complex care needs
Goal 5
To implement Population Health Promotion initiatives that support healthy aging and prevent deterioration of chronic conditions
Goal 6
To develop the infrastructure necessary to support future service renewal
Quality & Safety
Strategic Information
Communication
Information Technology
Finance
Human Resources
HCC Principles

Leading in the delivery of flexible and responsive services that focus on the desire of CLIENTS for Choice, Independence, and Dignity

Diagram 1



INTRODUCTION

Since 2002-03, Interior Health (IH) has implemented significant changes to the Home & Community Care (HCC) service delivery system and programs. The outcome of this round of system redesign will only begin to emerge in 2004-05 and will not be fully understood until subsequent years. As we look forward for the purpose of identifying the next cycle of initiatives, we are predicating our plans on the following assumptions: (a) that demand for services will increase due to a growing aging population, (b) the resources required to meet the demand will not increase at the same rate, and (c) the changes we are making now are transitioning us to the next phase of significant redesign.

The initiatives identified in this document are a reflection of our current knowledge of client needs and system challenges. As the context for health care and health reform continues to change both in BC and in Canada, the initiatives identified in this plan will require review and reprioritization. At this point in time, these initiatives are deemed to be critical for sustaining IH's ability to continue to deliver responsive, flexible, and appropriate Home and Community Care (HCC) services to seniors and adults with disabilities. In order to succeed, all of the initiatives will require leadership, strategy development, resourcing, and partnering relationships both inside and outside the organization.

This plan supports the achievement of the IH Strategic Goal 4:

> **To provide a network of facilities, services, and staff resources required to meet the needs of persons with acute, chronic, palliative, or rehabilitative health care needs through a range of caring, responsive, home care, assisted living, and residential care programs.**

STRATEGIC CONTEXT

Based on the New Era goals established by the Government of British Columbia in 2001, major strategic shifts are underway within health care. To achieve the goals of high quality, patient centered care in an affordable and sustainable public health care system, the Home and Community Care system will need to continue leading in strategic redesign initiatives.

The Home and Community Care system of the future will:

- Provide responsive and appropriate services to support individuals and their caregivers in remaining in the community
- Provide appropriate and high quality services in a residential setting for individuals who need a specialized environment
- Provide responsive and appropriate care to individuals who do not require the acute care setting, but do require a stay in a therapeutic environment prior to returning home
- Continue to seek new integrated models of service delivery and build on population health and preventive principles

Home and Community Care services provide a range of health and support services that are designed to supplement the efforts of individuals to care for themselves with the assistance of family and friends. The goals outlined in this document have been developed in alignment with:

- The Ministry of Health Services (MOHS) and Planning (MOHP) service plans and policies
- The recommendations of the Community for Life Report (Review of Continuing Care Services in British Columbia (1999)
- The Interior Health Quality Framework of responsiveness, system competency, work-life quality, and client and community focus
- The IH Board Strategic Directions and Goals
- The Goals and Initiatives of the IH Sector plans for Population and Public Health, Mental Health, Aboriginal Health, Acute Care, and Rural Health.

ENVIRONMENTAL SCAN

Many challenges confront the delivery of Home and Community Care services. Some of these challenges contribute to the ongoing difficulty of meeting increasing demands for service within constrained resources, while others provide opportunities for meeting needs in new and innovative ways. Examples include:

- Demographic shifts in the population including the increasing population of elderly, the smaller size of the nuclear family, and changes in the capacity of families to support family members with care needs
- Human Resource trends in the number of health employees approaching retirement
- Societal expectations for the level and types of services to be delivered, and the involvement of consumers in health care decision making
- Technological shifts that will continue to change options for care and care delivery
- Economic sustainability of the publicly funded health care system, including the proportion of the funding allocated to Home and Community Care Services

REVIEW OF 2002-03 HOME AND COMMUNITY CARE SERVICE PLAN

In April 2002, IH announced a redesign of the Home and Community Care services that was aligned with the New Era commitments of the Provincial Government and the 1999 Community for Life Report. Table 1 summarizes, for each of the six goals, the accomplishments that were achieved by March 31, 2004:

Table 1: Summary of Accomplishments

Home and Community Care Goals	2002-03 Milestones	2003-04 Milestones
Goal 1: To ensure Home and Community Care based services provide clients with the option of remaining as independent as possible in their own homes. **MOHS Performance Agreement Measures:** Increase the number of clients with high level care needs (IC2 and above) receiving services in their own home above the base number, as of March 31, 2002, **2001-02** 3,717 45% **2002-03** 3,791 48% **2003-04 (31 Dec 04)** 4,144 51.7% and; increase the percentage of these clients living in their own home, rather than in a facility specifically. • Target 2003/04 - 2% increase over prior year • Target 2004/05 - 5% increase over prior year • Target 2005/06 - To be determined. Benchmark to be developed in light of experience. **Linkages:** • MOHS Priority Strategy: 4[1], 6, 7, 8	• Standardized the levels of home support services across IH • Increased the number of clients with high care needs in the community • Increased access to adult day programs • Integrated service delivery structures within the Health Services Delivery Areas (HSA) of IH	• Established common standards for Adult Day Programs, Respite Services, and Hospice Palliative Care • Developed and implemented the framework for Services to Clients with Acquired Brain Injury • Developed a framework for Service to People with Dementia • Developed a Strategy for Hospice Palliative care
Goal 2: In partnership with BC Housing, increased the number of units and the range of housing environments into which personal and professional care can be provided. **Linkages:** • MOHS Priority Strategy: 4	• Initiated the Request for Proposal (RFP) process for the Private Rent component to the Independent Living BC program (ILBC) • Participated with the Ministry of Health Services in developing policies to support the development of the ILBC program	• Awarded contracts for 15 private rent supplements • Initiated the Expression of Interest (EOI) process for conversion of IH owned residential care homes to assisted living • Initiated the Expression of Interest process for the non profit component of the ILBC program • Developed the program manual for implementation of the ILBC program in IH
Goal 3: Continue to alleviate system pressure **Linkages:** • MOHS Priority Strategy: 1, 2	• Piloted and implemented models of care, including convalescent care	• Established common standards for addressing Alternative Level Care (ALC) • Piloted and implemented models of care, including convalescent care

[1] See Appendix A

Table 1: Continued

Home and Community Care Goals	2002-03 Milestones	2003-04 Milestones
Goal 4: To focus our residential services to clients with high and complex care needs.	• Standardized the number of residential care beds across IH, based on the population over the age of 75 years • Identified IH residential care homes requiring renovations and developed the renovation plans for high and complex care requirements • Implemented the Ministry of Health Services residential care access policy • Invested resources to address staffing levels resulting from increased acuity • Initiated the closure of residential care homes (both IH owned and operated and non amalgamated owned and operated) • Initiated the Request for Proposal process for construction of 8 new residential care homes • Completed the Request for Proposal process for 4 of the 8 new residential care homes • Commenced construction on 1 residential care home	• Developed a best practice framework for residential care • Commenced renovation of 9 of the priority IH owned residential care homes • Completed Request for Proposal process for 4 new residential care homes • Commenced construction on 5 new residential care homes See Appendix E for the Residential Care Bed Matrix Summary.
Goal 5: Implementing Population Health Promotion initiatives to support healthy aging and to prevent deterioration of chronic conditions. **Linkages:** • MOHS Priority Strategy: 7, 10, 11	• The lead for these initiatives is being provided through the Population and Public Health program and include Falls Prevention, Chronic Disease Management, and Influenza Vaccination	• Collaboratively with Population Health identified initiatives for Falls Prevention and Chronic Disease Management
Goal 6: Development of the infrastructure necessary to support renewal. **MOHS Performance Agreement Measures:** • Full implementation of the new assessment tool for home care (InterRAI-HC) over the next three years • Full implementation of the new assessment tool for residential care (InterRAI-HC V2.0) over the next five years **Linkages:** • MOHS Performance Agreement	• Developed plan and confirmed funding for implementation of the InterRAI HC • Developed IH policies to support management and practice within Home and Community Care • Developed and implemented a communication strategy to support Home and Community Care redesign • Developed knowledge base applications to monitor redesign process	• Implemented the InterRAI-HC in the Okanagan, East Kootenay, and Kootenay Boundary Health Service Areas (Thompson Cariboo Shuswap Health Area to be implemented in 2004-05). • Planning and preparation for implementation of Phase 1 for InterRAI 2.0 in to residential care. Implementation dependent upon securing the funding • Implemented Goldcare, Meditech registration, and Patient Care Inquiry (PCI) for Home and Community Care in Okanagan, KB, EK (TCS to be implemented in 2004-05) • Collaborated with Ministry of

Home and Community Care Goals	2002-03 Milestones	2003-04 Milestones
		Health Services on development of minimal reporting requirements for Home and Community Care • Development and implementation of strategy to 'turn off' use of CCIMS • Continued implementation of Home and Community Care Communication strategy

HOME AND COMMUNITY CARE SERVICE PLAN GOALS 2004-07

Goal 1: To ensure Home and Community Care based services provide clients with the option of remaining as independent as possible in their own homes.

Consultation across the province with clients and caregivers and reviews of the literature and research has provided direction for continuing to increase the range of services available to support clients in their own home, including strategies to support caregivers. This is consistent with an international trend away from a dependence upon residential care as the only option when a client's care needs increase. Ideally, the continued development of an expanded delivery system for clients in the community that is flexible and responsive will include: the promotion of self-managed care; the incorporation of best practice in case management for clients with multi-morbid conditions, chronic disease management and prevention; building upon cross-sector clinical practice guideline; the development of information systems; the development of appropriate policy and programs to meet the needs of specific client groups (i.e., brain injury, dementia); and compliance with the emerging Canada Health Act defined programs for Home Care.

The population served in community care is diverse in terms of both the client needs and the service options required. The availability of improved clinical data (through InterRAI), the implementation of information technology infrastructure, the focus of research on this sector, the (still being negotiated) changes to the Canada Health Act, and the emergence of clinical best practice evidence is creating opportunities to significantly reshape community care over the next three years.

The major initiatives to support this goal are outlined below:

1.1 Initiative: Sustainable System of Support for Caregivers

Description:

With increased pressure on the health system due to an increasing elderly population, changing public expectations and limited resources, caregivers must be recognized as our partners in ensuring the sustainability of Home and Community Care services. As key partners in the health system, caregivers have identified a need for education, information, and services to support them in their roles. Supporting caregivers and planning for minimizing caregiver burden, will ensure clients can be supported as long as possible in each care setting, thus lessening the need for crisis interventions and facilitating the appropriate use of health care services.

Milestones:

2004-05	2005-06	2006-07
• Within each Home and Community Care initiative, ensure information and support needs of the caregiver are priority strategies • Develop and implement measures of caregiver burden, including the necessary information infrastructure	• Develop a common best practice framework for caregiver support • Develop an implementation strategy • Identify and secure resources required to implement • Implement the caregiver support strategy • Identify key research areas related to caregiver support	• Evaluate caregiver support and information services • Secure funding to conduct research in key areas related to caregiver support

Measures:

- 0% increase in caregiver burden for Home and Community Care Long Term Care clients across IH
- Baseline utilization of health care service by targeted client caregiver groups

Challenges:

- This initiative will require changes to practice, health service culture, and policy

HCC Principle

Support for family, friends and other caregivers

- the family, friends and other caregivers are recognized and supported for their important role
- assisting family to understand clients right to self determination

Linkages:

- MOHS Priority Strategies: 4, 6, 7, 8, 10, 12
- IH Strategic Goal(s): 4
- Internal IH Linkages:
  - Population Health: Chronic disease management practice development related to self - managed care
  - Acute Care: Utilization of acute care service by LTC client caregiver(s)
  - Ambulance services: Ability to identify when a client and caregiver are on the Home and Community Care caseload
  - Mental Health: Information and education strategies for caregiver

Financial Implications:

- This initiative will have moderate, direct financial implications; however, increased appropriate utilization of health care services will benefit the system overall

1.2 Initiative: Palliative Care Service

Description:

The provision of quality services to ensure appropriate end of life care to individuals and the appropriate support to their families is a priority. To ensure that all residents of the IH area receive appropriate hospice palliative care services, a common standard framework has been developed, and a strategy for the development of services is currently underway. The participation of all Health Service sectors within the health services system (acute, residential, community and external

partners e.g. Hospice Societies and Cancer Centre for Southern Interior) is acknowledged as an important principle.

Milestones:

2004-05	2005-06	2006-07
• Implement service delivery standards • Identify and develop required IH policies to support service delivery • Identify and secure internal funding required • Establish data collection and documentation standards	• Continue to develop and implement required policies • Implement data collection and documentation • Generate preliminary information to support care delivery service management, monitoring, and planning • Develop plan to evaluate services	• Evaluate hospice palliative services • Review and update palliative hospice service plan

Measures:

- Number and location of deaths for clients receiving hospital palliative care service
- Palliative Care clients length of stay in hospital

Challenges:

- Need for education of staff and physicians in **all** settings regarding best practice
- Need for public education concerning hospice palliative care
- Mechanisms for ensuring physician support and remuneration
- Human resources
  - Appropriately skilled staff
  - Recruitment and retention of staff
  - Flexible staffing options

Linkages:

- MOHS Priority Strategies: 1, 2, 4, and 8
- MOHS Discussion Paper (October 2002) on a Provincial Strategy for End-of-Life Care in British Columbia
- Internal IH Linkages:
  - Acute Care

HCC Principle

Clients come first

- clients make their own health decisions based on their capabilities, values and goals. Substitute decision makers make these decisions when required.
- clients need to have full information about their situation and care options
- clients need to have autonomy in their decision making
- clients need to have an assurance the system will treat them fairly
- clients are valued members of their community
- clients are individuals with strengths and abilities upon which we build
- meeting individual client needs and exceeding expectations
- individual empowerment and responsibility means having information and having the right to live at risk

Financial Implications:

- New resources anticipated through the Federal Provincial Health agreement may be targeted to hospice palliative care

1.3 Initiative: Acquired Brain Injury (ABI) Service

Description:

Concurrent with the creation of six health authorities in BC, the responsibility for the delivery of services previously provided by the Provincial Brain Injury Program were devolved from the Vancouver Health region to the new Health Authorities. In 2001, the MOHS provided to Health Authorities 'Guidelines for Planning for Brain injury Service and Supports in British Columbia'.

As part of this devolvement, Health Authorities were requested to:
- develop an action plan with the various stakeholders consistent with these guidelines, and
- identify mechanisms to measure and report outcomes consistent with the MOHS Health Authority Accountability framework.

Interior Health undertook a "whole system" approach for planning the delivery of services to clients with a brain injury – resulting in a Strategic Framework for services (approved June 2003). This framework is currently being implemented and key milestones have been achieved.

Milestones:

2004-05	2005-06	2006-07
• Complete the implementation of the IH Acquired Brain Injury strategic framework • Initiate service planning process at IH and HSA levels and identify key service initiatives (including identification of resource requirements) • Complete initial evaluation of Acquired Brain Injury services based on AIMS standards for Acquired Brain Injury services	• Complete follow up evaluation of the Acquired Brain Injury services based on re-evaluation against AIM standards for Acquired Brain Injury • Implement priority service enhancements based on planning and resource availability • Develop information infrastructure to manage, monitor and plan services	• Continue implementation of priority service enhancements

Measures:

- Identification, by location, of clients with a brain injury receiving services.

Challenges:

- Minimal knowledge in the formal health care system regarding the service and clinical needs of clients with Acquired Brain Injury

Linkages:

- MOHS Priority Strategies: 1, 2, 4, 6, 12
- MOHS Guidelines for Planning for Brain injury Service and Supports in British Columbia, 2001
- Interior Health Brain Injury Framework 2004
- Internal IH Linkages:
  - Mental Health
  - Acute Care
  - Public Health

Financial Implications:

- In 2003, $400,000 was invested in Acquired Brain Injury services across IH. Additionally, the existing budget in the Brain Injury Program (devolved from VCHA) has been allocated to the HSAs to deliver services consistent with the IH Acquired Brain Injury framework. Future development will require additional resources.

1.4 Initiative: Dementia Care Services

Description:

Data from the Canadian Study on Health and Aging indicate that 9.2% of IH's population over the age of 65 will have dementia. Initial data for the InterRAI HC tool indicates that 40% of community dwelling Home and Community Care clients have a dementia. As the population ages, the needs of this population will continue to increase and the formal health system requires best practice strategies to care for individuals with dementia across all service delivery settings (community, residential and acute). Caring for individuals with dementia also represents a significant burden and challenge for the informal caregiver. The importance of partnerships with community-based organizations such as the Alzheimer Society is recognized as being critical to providing holistic, quality services to clients and families living with dementia.

Milestones:

2004-05	2005-06	2006-07
• Approval of a common best practice framework for dementia care across service sectors • Develop the implementation strategy for best practice framework • Identify and secure resources required to support implementation • Identify common information needed to plan for future dementia care services • Identify evaluation approach for dementia care best practice	• Evaluate dementia care best practice initiatives • Support the development of related best practice documentation specific identified areas (i.e. memory clinic, prevention/early identification, broad public education).	

Measures:

- Number of clients assessed as having dementia within Home and Community Care
- Utilization pattern of health services by clients with dementia
- Burden for caregivers of clients with dementia
- Progress in meeting best practice guidelines across sectors

Challenges:

- Recognizing specialized client sub-population within current service
- Need for education of staff and physicians in **all** settings regarding best practice
- Need for public education concerning dementia care

Linkages:

- MOHS Priority Strategies: 4, 7, 10, 12
- Internal IH Linkages:
  - Mental Health
  - Acute Care

Financial Implications:

- This initiative will have moderate, direct financial implications; however, increased appropriate utilization of health care services will benefit the system overall.

1.5 Initiative: Case Management Services

Description:

The reshaping of the Home and Community Care service system, the development of primary health care centres, and the introduction of chronic care models, will result in more clients being supported in their own home. The role of the Home and Community Care clinician will be impacted as the clinical needs and complexity of care coordination increase. Developing and implementing case management models for target client populations, and the partnering in these models with family physicians, chronic care management initiatives, and primary health care centres, will positively impact the clinical outcomes and the utilization of health services by clients and their caregivers. This change in practice will require planning, program development, role clarity, and policy and standard development to ensure consistent best practice across IH.

Recent research in BC has indicated a small percentage of clients are high users of health services. The development of case management models in Home and Community Care will contribute to improving appropriateness of health service utilization.

Milestones:

2004-05	2005-06	2006-07
• Identify the target client population requiring case management • Identify priority strategies or pilot projects including shared care model to improve care planning and service care delivery • Develop an evaluation framework • Identify resource requirements to support implementation • Develop system infrastructure to support the role and program development	• Identify priority strategies for implementation that build on year one initiatives • Continue to develop information support to identify clients, determine impact of new models of care delivery, and to continue to seek best practice strategies	

Measures:

- Number of clients identified as requiring case management intervention
- Change in utilization of health services resulting from case management of target client groups
- Improved quality and outcome measures (InterRAI data set) for clients accessing case management service

Challenges:

- Definitional and concept clarity regarding case management
- Building relationships with physicians and other sectors to support the model and roles

HCC Principle

Accessible and flexible services

- access to services are met in a flexible, timely and responsive manner,
- continuum of services that ensures smooth transition
- ongoing evaluation promotes innovation and continuous learning

Linkages:

- MOHS Performance Agreement (high needs clients in community)
- MOHS Priority Strategies: 1, 4, 5,7 10
- Internal IH Linkages:
  - Mental Health
  - Acute Care

Financial Implications:

- Resources required for training and education of service providers

1.6 Initiative: Post Acute Care Community Based Services

Description:

Home Care Nursing and Home Rehabilitation are the core services of community based post acute services in BC. Most of the focus of Home and Community Care redesign has been, to date, on the services provided for long term care clients; however, the post acute services comprise a significant component of the service system. Practice in this area has developed through local innovation since the first regionalization in BC (1997). This initiative will focus on determining current capacity for service and the identification of the appropriate client group to ensure effective utilization of health services. Opportunity exists to establish common standards for access and service levels. This client group increased 13.3% between 1999-00 and 2002-03 and future increases are expected as a result of demographics (aging population) and acute care utilization initiatives.

Milestones:

2004-05	2005-06	2006-07
• Define scope of the review through information analysis and review of current practice • Identify the target population for services • Develop the framework for post acute services • Identify and develop information infrastructure	• Secure resources required to implement priority initiatives • Implement the priority strategies • Identify key research areas related to post acute services	• Evaluate post acute care community based services • Secure funding to conduct research in key areas related to post acute care community based services

needed to manage and monitor program • Develop implementation plan for priority strategies		

Measures:

- Definition of access, quality criteria, outcome measures, and utilization measures
- Establish baseline measures

Challenges:

- Defining the scope for this initiative
- Defining core program standards will require a literature review of best practice and an inventory of current practice

Linkages:

- MOHS Performance Agreement: ALC (Alternative Level of Care) strategy
- MOHS Priority Strategies: 1, 2
- Internal IH Linkages:
  - ↳ Acute Care

Financial Implications:

- New resources from Federal Health dollars are anticipated to support these core services

1.7 Initiative: Aboriginal Elders' Health Services

Description:

Responsibility for planning the delivery of services to Aboriginal Elders is shared internally with the IH Aboriginal Health team and externally with Federal programs. The IH Aboriginal Health plan identifies as a priority the need to improve the delivery of services to this group of clients.

Milestones:

2004-05	2005-06	2006-07
• Refer to the Aboriginal Health Plan		

Measures:

- Refer to the Aboriginal Health plan

Challenges:

- Cultural sensitivity required to assess Aboriginal Elders Health Need
- Clarifying jurisdictional responsibilities for services

Linkages:

- MOHS Priority Strategies: 9
- Internal IH Linkages
  - IH Aboriginal Health Plan
  - IH Population Health Plan
  - Mental Health

Financial Implications:

- Resources are required to both develop and provide the services

1.8 Initiative: Health Services for Community Living Clients (HSCL)

Description:

Health Authorities are responsible for supporting the health needs of Community Living Clients served through MCFD. Changes within MCFD mandate and demographics for this client group have created increasing pressure on the service.

Milestones:

2004-05	2005-06	2006-07
• Identify the target population for services, both those turning 19 yrs and those whom are aging • Standardization across IHA of policy/procedures to support best practices in service delivery • Education re. staff advocacy role	• Continue to develop policies and procedures that support best practice for this population • Implementation of policies and procedure • Work on a residential model of care for this population group as required • Evaluation of care model	

Measures:

- Revised Ministry of Health Service Agreement to align with Ministry of Children and Family Development (MCFD) mandate
- Identification and baseline measure of the number of clients eligible for these services, including identification of potential clients in the MCFD system turning 19 years of age in each consecutive year.
- Standardization and implementation of policies, procedures, processes across Interior Health for this client population

Challenges:

- Changing role of MCFD and the need for partnership with them
- Maintaining the Community Living philosophy within fiscal environment

Linkages:

- Ministry of Children and Family Development
- Provincial Medical Consultant in Developmental Disability, Victoria
- Service Providers, i.e. Group Home and Private Care Home

Financial Implications:

- This population is increasing as survival rates improve for catastrophic childhood events and the adult client with developmental challenges ages at an earlier point in their life span. Increased resources are required.
- Identifying capacity within current funding model.
- Determine funding model that will work for this client population, i.e. individual client specific funding or contract relationship with MCFD

1.9 Initiative: Capacity Planning for Community Based Services

Description:

Prioritizing future capacity development for Home and Community Care based services requires measures of current service utilization and capacity as well as projections of future need and resources. Currently, predicting future service needs makes assumptions regarding historical utilization patterns and demographics. The provincial strategies directions emphasis on shift to more community based services. Modeling these shifts and the associated capacity needs requires new planning models

Milestones:

2004-05	2005-06	2006-07
• Develop approved utilization standard for home support hours and clients • Develop approved utilization standards for Adult Day program spaces and clients • Develop utilization indicators for post acute and LTC clients • Identify future resource requirements using simulation models	• Identify service capacity requirements to meet population growth and service substitutions	

Measures:

- Improved ability to predict capacity needs

Challenges:

- Inadequate information regarding demand and need for all service

Linkages:

- MOHS Priority Strategies: 4

Financial Implications:

- Modest initial investment into developing the planning model will be required

Goal 2: In partnership with BC Housing and other housing providers, create options for increasing the number of units and the range of housing environments into which personal and professional care can be provided.

A key premise of Home And Community Care redesign has been the role of emerging best practice housing models in which the preferred environment for maintaining clients' functional independence is in their own home. Supporting people to function in their own environments and supported by their social networks builds on the individuals functional capacity and maintains independence. Independent Living BC is an example of a program based upon housing and care models.

2.1 Initiative: Assisted Living Solutions in Rural Communities

Description:

The experience (since 2002), in developing assisted/supportive living models has highlighted the unique challenge presented by rural/remote communities. Developing housing and care solutions in rural/remote communities must balance cost effectiveness with service needs (this includes the investment into non–profit housing and care providers to strengthen capacity to deliver services). Innovative solutions are required including building on existing housing partnerships to enhance capacity. Other models of meeting the service need in these communities may need to be developed, piloted, and evaluated.

Milestones:

2004-05	2005-06	2006-07
• Develop partnership with third party service provider, IH and local community groups to develop local capacity • Develop and implement services in priority communities	• Evaluate effectiveness of service development in priority rural communities	

Measures:

- Successful development of assisted living in priority rural communities

Challenges:

- Lack of experience and knowledge in many communities regarding assisted living
- Affordability of rural models

Linkages:

- MOHS Priority Strategies: 4,12

HCC Principle

Community development

- build on and foster the ability of communities to address their own health issues
- HCC promotes client independence and normalized living in community based settings (consistent with cost effective and high quality care)

Financial Implications:
- Development of capacity to deliver assisted living in rural communities will require "up front" investment

2.2 Initiative: Complete the Implementation of Assisted Living Units

Description:

The IH 2002-03 Home and Community Care plan included the development of 772 Assisted Living units across the Health Authority, in partnerships with BC Housing. Six hundred and ninety four of the units are within the Independent Living British Columbia (ILBC) provincial program.

Milestones:

2004-05	2005-06	2006-07
• Open 308 assisted living units • Develop research and evaluation framework for assisted living • Initiate priority components of assisted living research and evaluation • Finalize program manual • Review priority access criteria for Assisted Living • Develop clinical and decision support information framework for assisted living	• Open 322 Assisted Living Units • Continue priority research and evaluation initiatives • Implement clinical and decision support information framework for assisted living	• Continue priority research and evaluation initiatives

Measures:

- 772 operating assisted living units across the HA by March 2006

Challenges:

- Construction costs in IH owned residential care homes being converted to assisted living
- Delay in the opening of assisted living units resulting from service provider capacity gap
- Accessing reliable data for evaluation purpose

Linkages:

- MOHS Priority Strategies: 4

Financial Implications:
- The financial implications are addressed in Budget Management Plan

2.3 Initiative: Service Capacity Planning for Assisted Living (AL)

Description:

Assisted Living is a new service model within the system of Home and Community Care. Using best practice planning parameters for the determining ideal service capacity is limited by:

- little experience with the model (6% of planned units open within IH by March 04)
- preliminary experience only with identifying clients appropriate for assisted living and not enough elapsed time to evaluate outcomes

The planning target of 13 units/1000 population over the age of 75 that is currently in place was based on a conservative estimate of the substitution potential for residential care. With current initiatives, Interior Health will have assisted living capacity of 14 actual units/1000 population 75+. The Ministry of Health planning methodology recommends a utilization target of 17 – 20 units/1000 population 75+ based upon a 'high substitution' shift from residential care.

Planning for assisted living in future will need to reflect appropriate service capacity to address the housing and care requirements of an increasing dementia population and the application of a rural factor applied to rural remote communities.

Milestones:

2004-05	2005-06	2006-07
• Confirm planning target for assisted living • Develop planning model for future capacity needs	• Review outcome from implementation of 772 assisted living units and adjust planning targets accordingly	

Measures:

- Number of clients on case loads who are appropriate for assisted living
- Length of stay (LOS) of clients in assisted living setting

Challenges:

- Addressing service capacity pressures if assisted living capacity is too low
- An increase in units will require BC Housing subsidy

Linkages:

- MOHS Priority Strategies: 4, 7, 10

Financial Implications:

- Increasing capacity above 772 units will require additional resources, including the housing subsidy

Goal 3: To continue to alleviate system pressure

Timely access to appropriate services is a key indicator of delivering effective services. Home and Community Care services must continue to meet a range of needs by providing expanded service choices and options. A lack of capacity in any part of the service system will result in inappropriate use of other services and waitlists. Strategies include provision of information and referral services

(HealthLink), expansion of acute substitution services (i.e., Home IV programs), development of convalescent services, and continued improvement in discharge and care coordination across the service continuum.

Outcomes expected will be a decrease in alternative level of care length of stay, the development of client and service proved 'friendly' referral and access systems, and improved coordination.

3.1 Initiative: Alternative Level of Care (ALC) Strategies

Description:

Responsibility for alternative level of care utilization is broader than Home and Community Care; however, there are strategies that can be consistently approached within Home and Community Care. These strategies include human resources planning, improved service access processes and structures, resource availability, and education.

Alternative Level of Care utilization is a key measure of system performance. Within IH, there is known variations both in utilization trends and causes of alternative level of care utilization between acute care sites.

Milestones:

2004-05	2005-06	2006-07
• Update alternative level of care report to determine current causes of alternative level of care utilization • Develop targeted solution, including convalescent care programs in residential care • Monitor impact of program, structure, process, and changes in impact in alternative level of care • Implement clinical information tools to identify client needs outside the acute care setting	• Update alternative level of care report to determine current causes of alternative level of care utilization • Develop targeted solutions • Monitor impact of program, structure, process, and changes in impact in alternative level of care	• Update alternative level of care report to determine current causes of alternative level of care utilization • Develop targeted solution, including convalescent care programs in residential care • Monitor impact of program, structure, process, and changes in impact in alternative level of care

Measures:

- Decrease in alternative level of care utilization at acute care sites

Challenges:

- Identifying groups of clients for whom a targeted program solution can be developed

Linkages:

- MOHS Priority Strategies: 1, 3
- Internal IH Linkages
  - Acute Care plan
  - Sub acute care service development (Provincial Policy Development)

Financial Implications:

- New or reallocated resources will be required to implement new service models and to increase capacity in programs demonstrating effectiveness

Goal 4: To focus our residential services on clients with high and complex care needs

The provincial strategy to increase options for clients to remain in their own home has resulted in a change in the criteria for admission to residential care. Clients entering into residential care homes have high and complex care needs and the types of services provided in the residential care setting are shifting to include more options for palliation, respite, transitional/reactivation, and convalescent care in addition to traditional residential care. Strategies for achieving this shift in care will continue to include: upgrading or replacing physical plants that are inappropriate for high care needs; reallocation of resources to high needs and specialized units (complex medical care or complex dementia care); and consistently applying best practice models within residential care.

Initiatives to achieve this goal include:

4.1 Initiative: Complete Closure of Residential Care (RC) Homes and Opening of New Homes

Description:

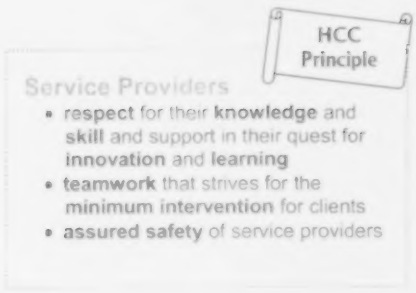
The 2002-03 Home and Community Care service redesign plan identified the closure of residential care homes based on two objectives: (1) equitable bed planning targets consistently applied across IH based on 75 beds per thousand population over seventy five for urban communities and 82.5 beds per thousand population over seventy five for rural communities, and; (2) residential care homes needing to be replaced because of functional and physical deficiencies in the physical plant. Approximately 986 beds will be closed in 2004-05. Nine new/ renovated residential care homes that can accommodate high and complex care needs will open across IH in 2004-05 and 2005-06.

Milestones:

2004-05	2005-06	2006-07
• Closure of 986 beds • Opening of 7 new residential care homes (Williams Lake, Kamloops, Salmon Arm, Vernon, Penticton, Trail, and Fernie)	• Opening of 2 new residential care homes (campuses: Summerland and Nelson)	

Measures:

- Revised Bed matrix, by community, consistent with 2002-03 Home and Community Care service redesign plan
- Improved functionality of bed stock (% of beds appropriate for high and complex care clients over 2002 base)


HCC Principle
Service Providers
• respect for their knowledge and skill and support in their quest for innovation and learning
• teamwork that strives for the minimum intervention for clients
• assured safety of service providers

Challenges:

- Ensuring quality of care to clients through the moves related to these closures and openings
- Public response to closures of residential care beds

Linkages:

- MOHS Priority Strategies: 6
- MOHS policy regarding Access to Residential Care

Financial Implications:

- The resources for this initiative are addressed in the Budget Management Plan

4.2 Initiative: Best Practice in Residential Care (RC)

Description:

Best practice in residential care reflects a philosophical shift from a medical focus to one that is more social and client focused. A client-centered model of care places the power with the client. It views the client in a holistic manner with a focus on capabilities; and care is delivered in a supportive manner that eliminates boredom, loneliness, and helplessness. This model permeates all relationships within the residential care home and is reflected in both how management interacts with staff and how staff interacts with residents. The client-centered model can also be seen in how the residential care home is decorated and what programs and activities take place at the home (i.e. intergenerational programs, and pet therapy).

A shift to a more socially focused delivery of care is important to 3 primary stakeholders: residents of residential care homes, staff of residential care homes, and family/friends of residents. It requires a planned implementation that focuses on senior leadership commitment, culture shift, management practice, staff skill, mix and practice, and the review of policies and procedures.

Milestones:

2004-05	2005-06	2006-07
• Develop a common framework for best practice in residential care • Identify priority strategies for implementing best practice across all IH residential care homes • Implement priority best practice strategies • Develop an evaluation framework for monitoring progress to best practice • Identify and implement information systems for decision support in residential care	• Evaluate progress on implementing best practice • Continue to implement priority strategies to achieve and sustain practice changes	

Measures:

- Increased LTC resident satisfaction survey
- Quality indicators (through service contract initiative)

Challenges:

- Requires a cultural, practice, and policy shift in all residential care homes

Linkages:

- MOHS Priority Strategies: 4, 7
- Performance Agreement (implementation of InterRAI 2.0)

Financial Implications:

- Current budget plan has resources set aside for this initiative

4.3 Initiative: Plan and Implement Strategies to Address Staffing

Description:

Staffing levels and mix must continue to be addressed to ensure the continued ability to deliver quality residential care. The change in access criteria for residential care is resulting in an increase in the number of clients with high and complex needs. In addition, we are seeing a greater differentiation in the types of service in residential care including palliative, transition, reactivation, and convalescent. Each service type will require a review of staffing and supply costs compared to the historical staffing levels in residential care. While continued efforts are made to ensure cost effective solutions are implemented, the needs of the clients and the impact of shorter length of stays may mean additional resources are required if bed numbers are to be maintained.

Milestones:

2004-05	2005-06	2006-07
• Review staffing levels and mix in residential care homes • Develop residential care staffing benchmark standards that is built on clinical practice principles an quality of care • Evaluate ability of residential care homes to meet benchmarking standards • Develop strategies for each home to meet the approved staffing benchmark standards	• Continue to review staffing levels in residential care as best practice initiatives are implemented	

Measures:

- Direct care staffing hours / bed/ day
- RN/LPN staffing mix / bed / day
- Quality and Outcome indictors (InterRAI based)

Challenges:

- Financial constraints and quality and outcome measurement constraints

Linkages:

- IH Home and Community Care Initiative 4.2 – Best Practice in Residential Care

Financial Implications:

- Additional resources are anticipated to be required to meet client needs and maintain safe quality care

4.4 Initiative: Service Capacity for Residential Care

Description:

The residential care service component of Home and Community Care is significantly impacted by the provincial strategic direction to create increased options for care outside of the residential care environment. Interior Health will continue to monitor the need for beds based upon the planned levels established in the 2002-03 Home and Community Care Plan. The resources required to meet the planning target are partially identified in the 2004-07 Budget Management Plan and approximately 405 new units will be developed over the next two years (see Appendix E).

The 2002-03 Home and Community Care plan for IH was based on a target capacity of 75 beds/1000 population over 75 (+10% for rural communities). In 2004-05, IH will have 67.8 beds/1000 population over 75 as a result of increases in the population. The MOH HCC planning model, which assumes a high substitution for residential care by assisted living and community options, projects a requirement for 65.4 beds/1000 population over 75 by 2006.

Milestones:

2004-05	2005-06	2006-07
• Develop the residential bed plan based upon agreed upon bed targets, functional and physical status of homes and the need for specialized services • Evaluate priority access standards for residential care • Identify available resources for future development • Identify and implement priority residential care capacity development strategies by community	• Continue implementation of priority residential care capacity development strategies	• Continue implementation of priority residential care capacity development strategies

Measures:

- Residential care beds /1000 population over 75 by LHA
- Indicator for quality of access to residential care

Challenges:

- Financial resources required to maintain planning targets
- Provincial policy regarding substitution of housing and community options for residential care based service

Linkages:

- MOHS Priority Strategies: 4

Financial Implications:

- Cost to increase beds by 469 to meet 2004-05 planning target is approximately $23.4m
- Cost to increase beds by an additional 440 to meet 2007-08 planning target is approximately $22.0m.

4.5 Initiative: Residential Care Renovations

Description:

In the 2002-03 to 2004-05 Home and Community Care plan, approximately $20m was invested in improving the functional design of residential care homes (IH owned and operated) to ensure the capacity of those residential care homes to appropriately and safely meet the needs of clients with high and complex care needs. Additional dollars were also invested in ceiling lifts and other equipment / physical plant upgrades. There remain several residential care homes across the health authority that were built to intermediate (smaller rooms/ bathrooms) or extended care (four bed wards and minimal home-like features) standards. The desired outcome of the functional upgrades is to achieve 100% of IH bed stock as meeting functional and physical design requirements that facilitate the delivery of client centred best practice and allow for safe and appropriate care to clients.

Milestones:

2004-05	2005-06	2006-07
• Identify physical and functional fit of remaining residential care homes based on standards required for delivering care to high and complex care clients • Identify priority residential care homes for renovation • Identify resources required for renovations • Develop site specific scope definition for each renovation	• Initiate approved renovations	• Review physical and functional fits of residential care homes

Measures:

- Increase in number of beds meeting high and complex care functionality by Local Health Authority (LHA), Health Service Area (HSA), Interior Health (IH)

Challenges:

- Financial Resources required for renovations

Linkages:

- IH Strategic Objective: 4
- Internal IH Linkages
  - ↳ Capital & Facilities Planning

Financial Implications:

- Capital funding source required

Goal 5: To implement Population Health Promotion initiatives that support healthy aging and prevent deterioration of chronic conditions.

Taking a population health promotion approach to health issues is a critical component of any service plan, because of the importance of working toward sustainability of the health care system.

Initiatives under this goal are in partnership between Population Health and Home and Community Care.

5.1 Initiative: Falls Prevention

Description:

Across IH, a number of initiatives have been undertaken to reduce falls in the senior population. Diffusing the learnings from these initiatives and embedding emerging research into day-to-day clinical practice will require a structured, planned approach. Additional opportunity now exists to reduce the incidence of falls in the senior population with the InterRAI HC tool and supporting technology being implemented across the health authority.

Milestones:

2004-05	2005-06	2006-07
• Develop partnership with Population Health Unit on Falls Prevention initiatives • Identify Falls Prevention Strategy for two (2) target population groups: 1. community living clients receiving Home and Community Care services 2. clients living in residential care	• Diffuse Falls Prevention initiatives across Interior Health • Identify for implementation new Falls Prevention strategies based upon learnings in 04-05	• To be completed

• Initiate priority IH wide strategies • Develop and implement information infrastructures to measure and monitor falls for the target client group • Develop sustainability plans for initiative currently underway		

Measures:

- Develop baseline measure for falls by client group
- Set reduction target

Challenges:

- Measurement and data collection limitations

Linkages:

- MOHS Priority Strategies: 10
- BC Injury Prevention Research
- Internal IH Linkages
  - ↳ IH Population Health Plan

Financial Implications:

- This initiative can be addressed through existing resources and external research funding source

5.2 Initiative: Healthy Aging

Description:

The purpose of this initiative is to improve the health of the seniors population through applying the principles and frameworks of Population Health and Prevention to the issue of aging. Understanding the determinants of health in this population, developing and encouraging health policy development at the local and provincial level, and improving the skills and knowledge of the general population to make health and self -care decisions that are informed and research based would comprise the basic elements of the strategy.

Milestones:

2004-05	2005-06	2006-07
• Review best practice in Healthy Aging from National and International Jurisdiction • Select the best practice approach • Develop multi year strategy		

Measures:

- Clearly articulated strategy for promoting Healthy Aging

Challenges:

- Balancing the time needing to be invested in a long term strategy like Health Aging with the time consuming imperatives of short term initiatives

Linkages:

- MOHS Strategic Priority 11
- Internal IH Linkages
  - ↳ IH Population Health Plan

Financial Implications:

- Minimal investment of resources will be required

HCC Principle

Health is the goal

- focus is on promoting well being, independence and or interdependence
- the right to dignity, privacy and self determination which means the right to make choices based on their values and have freedom to live normally (as defined by the client)

Goal 6: Development of the infrastructure necessary to support future service renewal.

Effective implementation of the Home and Community Care redesign is dependent on the concurrent development and strengthening of the infrastructure to support the programs and services. Infrastructure development includes:

6.1 Initiative: Service Capacity Planning

Description:

The 2003 Home and Community Care plan was developed using utilization targets that were based on historical patterns of use and an assessment of actual service experience with different service capacities. With the reduction in residential care beds, the change in access to residential care, the creation of the Assisted Living program, the refocusing of home support on personal care, the increase in Adult Day Programs and increases in palliative care, the development of an interactive service capacity planning tool for determining future capacity needs is required.

The concept is one of an interactive service capacity planning tool that incorporates client characteristics, service characteristics, and system throughput assumptions and that will assist IH to determine the future needs for community based capacity, housing and care capacity and residential care capacity and bed mix.

The Ministry of Health has used a planning model that has been helpful during this transition period; however, it is predicated primarily on diversion away from residential, is based on the old classification system and, does not address community capacity needs (i.e. only addresses residential care and makes broad assumptions of assisted living). The development of a tool to support future planning that incorporates emerging data sets and assumptions (i.e., InterRAI client assessments for client grouping, outcomes and quality, actual experience in throughputs for community care, assisted living and residential care), is adaptive to include new service delivery models, and is applicable to LHA, HSA, and HA level planning is critical to support decisions related to the allocation of scarce resources to service capacity.

Milestones:

2004-05	2005-06	2006-07
• Identify available applications and / or models for the development of the planning tool • Resource the development of the tool for use in Home and Community Care planning	• Apply planning tool to Home and Community Care planning • Refine planning tool based on application to Home and Community Care context	• Incorporate into planning process

Measures:

- Improved service capacity planning decisions

Challenges:

- Technology availability to develop service capacity planning tool and the availability of quality data to populate the tool

Linkages:

- Internal IH Linkages
  - Strategic Information

Financial Implications:

- Minimal for tool development

6.2 Initiative: InterRAI Implementation

Description:

The implementation of the InterRAI Home Care (HC), and 2.0 residential assessment tools is mandated by MOHS by 2005 and 2007 respectively. In addition the care planning and documentation module of the assessment software will help clinicians work with clients and their caregivers/families to address care needs more fully. The use of data from these assessment tools to inform decision making and performance monitoring as well as the link to information support with the MOHS forms the basis of the Decision Support initiative related to the RAI implementation.

The implementation of InterRAI HC and InterRAI 2.0 residential will generate changes in clinical practice that will facilitate emerging best practices. In addition, the qualitative and quantitative data available from the assessment software will provide solid information for decision-making, strategic planning, program development and resource utilization.

Milestones:

2004-05	2005-06	2006-07
• Complete implementation of the InterRAI-HC	• Complete project evaluation of the InterRAI-HC • Develop and implement ongoing education/upgrade training	• Ongoing clinical support

	plan for sustainability	
• Pilot phase of the 2.0 – implementation in one residential care home including evaluation and planning for future phases • Begin development of standardized care planning – beginning with clients assessed with the InterRAI-HC tool • Planning for implementation of automated care planning with the InterRAI-HC tool • Research and develop standards for care planning across the HCC continuum	• Implementation of the 2.0 to a series of residential care homes in phases • Ongoing evaluation of implementation • Further development, evaluation of care planning	• Continued implementation of 2.0

Measures:

- Full implementation of InterRAI HC
- Implementation of the InterRAI 2.0 in residential care homes

Challenges:

- The implementation of these tools significantly impacts front line clinicians. Good change management models are essential to achieving successful implementation.

Linkages:

- MOHS Performance Agreement
- Internal IH Linkages
  - ↳ Information Technology

Financial Implications:

- Implementation of InterRAI 2.0 beyond the pilot in 2004-05 will require project funding

6.3 Initiative: Advanced Care Planning

Description:

Research completed in Ontario has suggested that the implementation of an advanced care planning program (i.e. Let Me Decide, Respecting Choice) will result in quality end-of-life decision making by clients. Provincially, work is underway to review models and principles for advanced care planning and to assess the readiness of BC for advanced care planning. Interior Health will work collaboratively with the provincial initiative.

Milestones:

2004-05	2005-06	2006-07
• Collaborate with provincial agencies in reviewing models for advanced care planning • Participate, through provincial initiatives, in the development of a provincial strategy • Develop strategy for IH, consistent with the provincial framework • Identify resources required to support implementation	• Secure necessary resources to support IH implementation • Implement strategy	

Measures:

- Utilization of health services by individuals who have advanced care plans

Challenges:

- Social acceptance of the concept

Linkages:

- None

Financial Implications:

- Implementation will require funding with both one-time and ongoing costs

6.4 Initiative: Quality Improvement

Description:

Integral to the Home and Community Care Service Plan is the need to both imbed quality improvement principles within each Home and Community Care initiative, and apply quality improvement principles to Home and Community Care system wide practices. Home and Community Care quality improvement practices will align with the IH Quality Improvement framework of:

- Responsiveness
- System Competency
- Client/Community Focus
- Work life Quality

Milestones:

2004-05	2005-06	2006-07
• Identify priority Home and Community Care system practices for quality improvement opportunities • Design and conduct the	• Identify priority Home and Community Care system practices for quality improvement opportunities • Design and conduct the	• Identify priority Home and Community Care system practices for quality improvement opportunities • Design and conduct the

quality improvement initiatives • Address recommendation arising from the review	quality improvement initiatives • Address recommendation arising from the review	quality improvement • Address recommendation arising from the review

Measures:

- Quality improvement initiatives are identified and completed
- Recommendations received and actioned

Challenges:

- None

Linkages:

- IH Strategic Objective: 11

Financial Implications:

- Quality imitative will be conducted within existing resources

6.5 Initiative: Decision Support & Information Development

Description:

A framework for information, decision support, and the culture to support and value the knowledge derived from information, is required to support emerging best practice, clinical decision making, program development, strategic planning and resource allocation. The quality of the information for Home and Community Care will increase with the implementation of the InterRAI tools (home care and residential) and the roll out of the Meditech systems. Information development is also required for the other Home and Community Care program areas not involved with InterRAI assessment implementation (i.e. HCN, Home Rehab). The ongoing development of the decision support information framework for Home and Community Care links to the work being developed in Strategic Information, Research, Finance, and the development of the Provincial minimum reporting requirements for Home and Community Care.

HCC Principle

Accountability

- improvement of quality of life and achievement of client goals
- emphasis on positive outcomes, research and best practice
- use of resources in most effective/efficient way
- balance need for best utilization of resources with changing service needs

Milestones:

2004-05	2005-06	
• Complete the development of the Home and Community Care decision support information management framework • Integrate the InterRAI data sets into clinical, management and system decision making • Determine the feasibility of	• Resourcing and implementing business objectives for the Home and Community Care information needs • Reviewing and improving Home and Community Care reporting systems	

utilizing the business objects • Meet Ministry of Health Services minimum reporting requirements through IH clinical and administration system		

Measures:

- Completion of the decision support management framework for priority programs

Challenges:

- Retire CCIMS reporting and replace with direct reporting to MOH via Meditech

Linkages:

- IH Strategic Objective: 8
- IH Information Technology (IT) Department Tactical plan

Financial Implications:

- Within existing resources

6.6 Initiative: Research and Development

Description:

Future Home and Community Care services will benefit from the integration of research activities into the current planning and development activities. Results from the research initiatives will support learning and inform policy and program decision making. Through partnerships with the IH Strategic Information and Research unit and external agencies, Home and Community Care will engage in priority research activities.

Milestones:

2004-05	2005-06	2006-07
• Identify priority Home and Community Care research initiatives • Secure resources to conduct the Home and Community Care research activities through submission to a research funding agency • Implement research initiative	• Report outcome of Home and Community Care research initiative (recommendations)	

Measures:

- Number of research initiatives underway

Challenges:

- Limited research capacity within IH
- Ability to access external research funding source

Linkages:

- IH Strategic Objective: 11

Financial Implications:

- To be supported within existing resources and external research funding agencies.

Appendix A: Ministry of Health Services Goals & Objectives

Ministries of Health Service Plans

Ministry Goals (MOHS & MOHP) (03/04)

Goal 1: High Quality Patient-Centred Care
Goal 2: Improved Health and Wellness for British Columbians
Goal 3: A Sustainable, Affordable Public Health System

Services Delivered by Partners/Ministry

Five Key Objectives

Partners:

1. Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/institutional care to more home/community care.
2. Provide tailored care for key segments of the population to better address their specific health care needs an improve their quality of life.
3. Keep people as healthy as possible by preventing disease, illness and disability and slowing the progression of chronic illness to minimize suffering and reduce care costs in the future.
4. Manage within the available budget while meeting the priority needs of the ministry population.

Ministry

5. Provide clients with equitable and timely access to services delivered by the Ministry.

15 Priority Strategies

Partners:

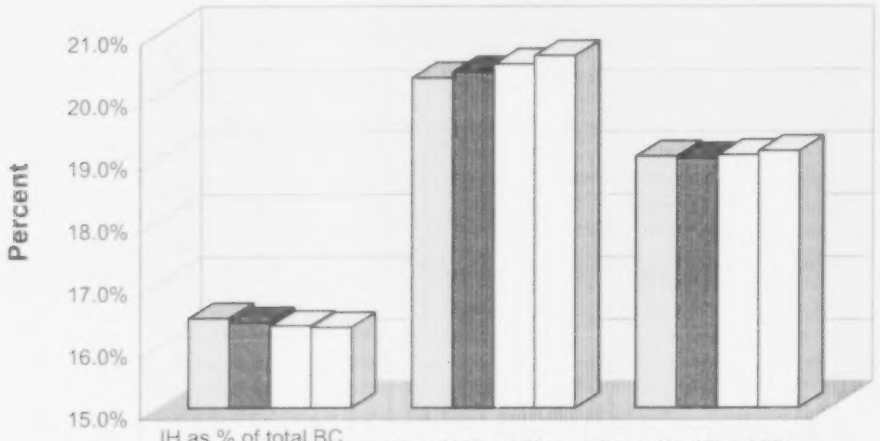
1. Prevent hospital admissions through primary care and community options
2. Provide post acute (hospital) alternatives
3. Manage acute care needs in hospital
4. Provide alternative to institutional care
5. Building integrated care networks a. Connect physicians and other health care professionals to diagnostic services, to hospitals, and to each other. b. Provide a continuum of services in each health authority for mental health patients that better integrates primary, secondary, community and tertiary mental health care and is integrated with the larger care networks.
6. Improve care for people with extensive care needs
7. Improve care for people with chronic conditions
8. Improve care for the dying
9. Improve the health status of Aboriginal peoples
10. Enhance self-care and self-management
11. Prevent disease and injury
12. Enhance service quality for rural and smaller communities
13. Manager within budget allocation

Ministry

14. Improve integration of the provincial ambulance service within the overall health system
15. Improve registration services to the public

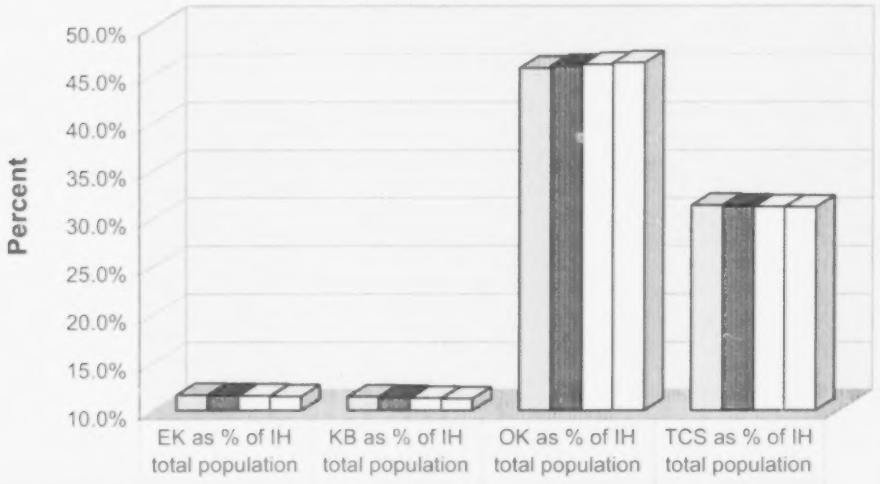
Appendix B

Projected BC Population Comparisons/Growth



	IH as % of total BC population	IH as % Total 75 +	IH as % of Total 85+
2004/2005	16.4%	20.3%	19.0%
2005/2006	16.4%	20.4%	19.0%
2006/2007	16.3%	20.5%	19.1%
2007/2008	16.3%	20.6%	19.1%

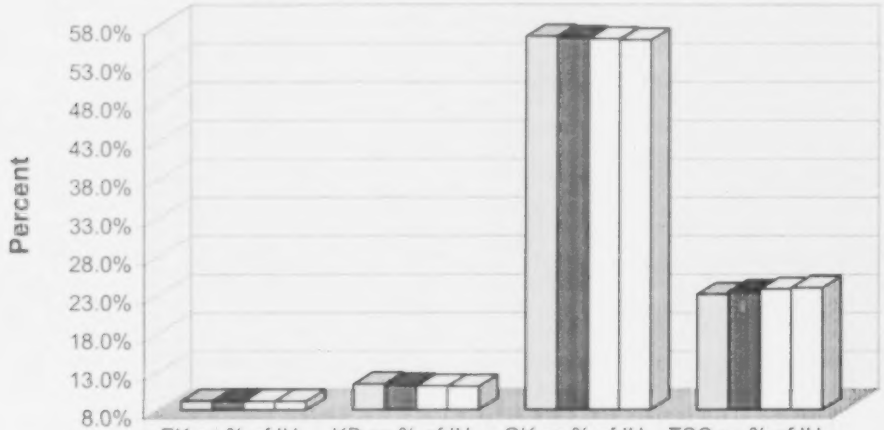
Projected IH Total Population Comparisons/Growth by HSA



	EK as % of IH total population	KB as % of IH total population	OK as % of IH total population	TCS as % of IH total population
2004/2005	11.6%	11.4%	45.6%	31.3%
2005/2006	11.6%	11.4%	45.8%	31.2%
2006/2007	11.5%	11.3%	46.0%	31.2%
2007/2008	11.5%	11.2%	46.2%	31.1%

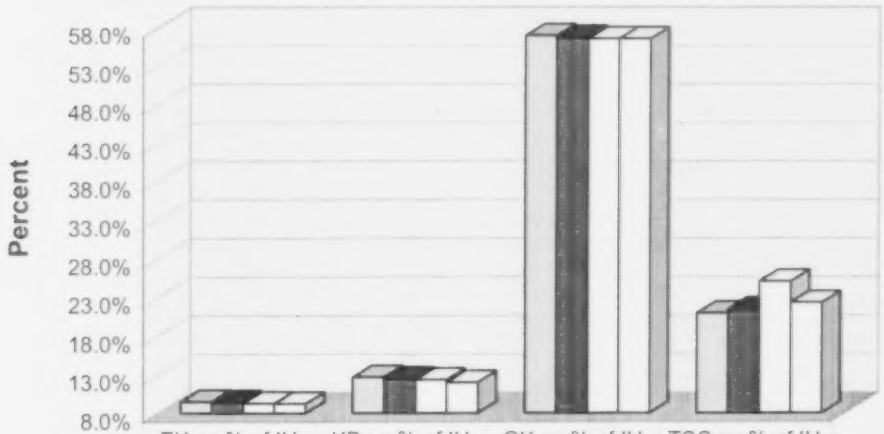
Appendix B

Projected IH Population 75+ Comparisons/Growth by HSA



	EK as % of IH total 75+	KB as % of IH total 75+	OK as % of IH total 75+	TSC as % of IH total 75+
2004/2005	9.2%	11.3%	56.5%	23.0%
2005/2006	9.2%	11.2%	56.3%	23.3%
2006/2007	9.1%	11.1%	56.2%	23.7%
2007/2008	9.1%	11.0%	56.0%	23.9%

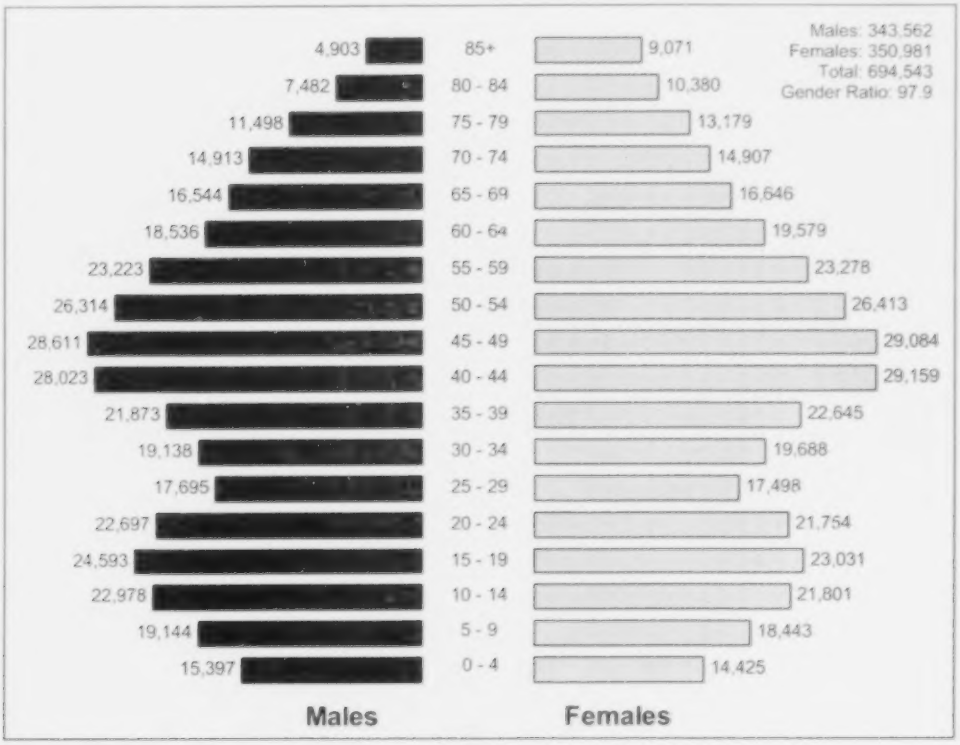
Projected IH Population 85+ Comparisons/Growth by HSA



	EK as % of IH total 85+	KB as % of IH total 85+	OK as % of IH total 85+	TSC as % of IH total 85+
2004/2005	9.5%	12.6%	56.9%	20.9%
2005/2006	9.4%	12.4%	56.7%	21.4%
2006/2007	9.3%	12.3%	56.5%	25.0%
2007/2008	9.2%	12.0%	56.5%	22.3%

Appendix C

Interior Health Population by 5-Year Age Group and Gender (2004)



Source: PEOPLE 28

Appendix D: Utilization Graphs

This section is being updated with 2003-04 information.

Appendix E

Home & Community Care
Residential Care Bed Matrix Summary

East Kootenay HSA	Original Bed Numbers as at April 2002	Operating Current Approved Beds 2004 [1]	Beds per 2004-07 HCC Service Plan [2]	Beds Needed 2009/10 Based on 75 Beds/1000 Pop. 75 +
Fernie - R	**58**	**50**	**50**	**56**
Fernie Hospital, Fernie	8	0	0	
Tom Uphill, Fernie	50	0	0	
Rocky Mountain Village, Fernie *		50	50	
Cranbrook	**167**	**120** [3]	**133**	**135**
Dr. Green Home, Cranbrook	58	58	58	
A'Qam Care Centre, Cranbrook	5	0	0	
Rocky Mountain Lodge, Cranbrook	60	15	0	
Steepleview Care Centre, Cranbrook	44	47	0	
New Facility, Cranbrook			75	
Kimberley - R	**69**	**51**	**51**	**62**
Kimberley Hospital	18	0		
Kimberley Special Care Home, Kimberley	51	51	51	
Windermere - R	**20**	**20** [4]	**30**	**45**
Columbia House, Invermere	15	15	30	
Acute, Invermere	5	5	0	
Creston - R	**173**	**110**	**110**	**113**
Swan Valley Lodge, Creston	103	90	90	
Creston District Hospital, Creston	20	20	0	
Pioneer Villa, Creston	50	0	0	
New Facility, Creston			20	
Golden - R	**37**	**26**	**26**	**31**
Henry Durand Manor, Golden	30	26	26	
Golden Hospital	7	0	0	
Total For EK HSA	**524**	**377**	**400**	**442**

[1] Approved by East Kootenay Leadership Team June 2004.
[2] The final planned beds resulting from the 2002-04 plan. Some bed numbers have changed as a result of the final outcome of renovations or operational plans. This column captures where IH will be once the current round of renovation, closures and new builds are complete. **They are not intended to capture the transitional changes in numbers as the plan is implemented.**
[3] With the closing of A'Qam, Cranbrook is short in 2004 operating capacity of 3 approved beds (excluded from 2004 count).
[4] Windermere is short operating capacity of 10 approved beds, which will open when the renovations are complete (excluded from 2004 count).
* Campus of Care

Kootenay Boundary HSA	Original Bed Numbers as at April 2002	Operating Current Approved Beds 2004 [1]	Beds per 2004-07 HCC Service Plan [2]	Beds Needed 2009/10 Based on 75 Beds/1000 Pop. 75 +
Arrow Lakes - R	**66**	**38**	**38**	**37**
Arrow Lakes Hospital, Nakusp	4	8	8	
Halcyon Home, Arrow Lakes	27	0	0	
Slocan Hospital, New Denver	30	30	30	
Slocan EC	5	0	0	
Grand Forks/KV - R	**96**	**67**	**67**	**101**
Boundary Hospital, Grand Forks	35	35	35	
Hardy View Lodge, Grand Forks	32	32	32	
Boundary Lodge, Grand Forks	29	0	0	
Castlegar	**105**	**105**	**105**	**76**
Talarico Place, Castlegar	60	60	60	
Castleview Care Centre, Castlegar	45	45	45	
Nelson/Kootenay Lake	**196**	**137**	**137**	**172**
Nelson Jubilee Manor, Nelson	32	32	32	
Mount St Francis, Nelson	79	85	0	
Willowhaven, Nelson	70	0	0	
Victoria Hospital, Kaslo	15	20	20	
Mountain Lake Seniors Community, Nelson *	0	0	85	
Trail	**276**	**156**	**156**	**147**
Columbia View Lodge, Trail	99	76	76	
Poplar Ridge, Trail	50	50	50	
Kiro Manor, Trail	86	0	0	
Mater Misericordiae, Rossland	41	0	0	
Rosewood Village, Trail *	0	30	30	
TOTAL for KB HSA	**739**	**503**	**503**	**533**

[1] Approved by Kootenay Boundary Leadership Team June 2004.

[2] The final planned beds resulting from the 2002-04 plan. Some bed numbers have changed as a result of the final outcome of renovations or operational plans. This column captures where IH will be once the current round of renovation, closures and new builds are complete. **They are not intended to capture the transitional changes in numbers as the plan is implemented.**

* Campus of Care

Okanagan HSA	Original Bed Numbers as at April 2002	Operating Current Approved Beds 2004 [1]	Beds per 2004-07 HCC Service Plan [2]	Beds Needed 2009/10 Based on 75 Beds/1000 Pop. 75 +
Vernon	**391**	**307**	**382**	**429**
Heritage Square (Bethany Home), Vernon *	37	50	50	
Noric House, Vernon	91	85	85	
The Gateby, Vernon	100	75	75	
Polson Place, Vernon	97	97	97	
Alexander Wing, Vernon	66	0	0	
New Facility (ies), Vernon	0	0	75	
Armstrong	**70**	**40**	**40**	**59**
Pleasant Valley Manor, Armstrong	40	40	40	
Pioneer Square (Willowdale), Armstrong	30	0	0	
Enderby	**47**	**31**	**31**	**50**
Parkview Place, Enderby	31	31	31	
Juniper Court, Enderby	16	0	0	
Central Okanagan	**1057**	**974**	**1114**	**1282**
LTC Beds at KGH	2	0	0	
Brookhaven, Kelowna	84	84	84	
Sun Pointe, Kelowna *	100	100	100	
Windsor Manor, Kelowna	82	82	82	
Pine Acres, Westbank	40	40	40	
Westside Care Centre, Kelowna	77	77	77	
Lake Country Manor, Lake Country *	32	32	32	
Cottonwoods, Kelowna	276	261	261	
David Lloyd Jones, Kelowna	78	50	50	
Still Waters Private Hospital, Kelowna	79	79	79	
Sutherland Hills, Kelowna	88	88	88	
Three Links Manor, Kelowna	81	81	81	
Joseph Benjamin, Kelowna	38	0	0	
New Facility, Kelowna	0	0	90	
New Facility, Westbank	0	0	50	
Penticton	**396**	**369**	**369**	**422**
Moog & Friends Hospice House, Penticton	8	12	12	
Trinity Care Centre, Penticton	76	75	75	
Westview Extended Care, Penticton	130	100	100	
Haven Hill Retirement Centre, Penticton	82	82	82	
Penticton & District Retirement	100	0	0	

[1] Approved by Okanagan Leadership Team June 2004.

[2] The final planned beds resulting from the 2002-04 plan. Some bed numbers have changed as a result of the final outcome of renovations or operational plans. This column captures where IH will be once the current round of renovation, closures and new builds are complete. **They are not intended to capture the transitional changes in numbers as the plan is implemented.**

* Campus of Care

Okanagan HSA	Original Bed Numbers as at April 2002	Operating Current Approved Beds 2004 [1]	Beds per 2004-07 HCC Service Plan [2]	Beds Needed 2009/10 Based on 75 Beds/1000 Pop. 75 +
Centre, Penticton				
Village at the Station, Penticton *	0	100	100	
Summerland	**164**	**129**	**125**	**131**
Summerland Extended Care, (Dr Andrew Pavilion) Summerland	50	50	50	
Summerland Lodge, Summerland	35	0	0	
Kelly Care Centre, Summerland	79	79	0	
Summerland Seniors Village, Summerland *	0	0	75	
Princeton - R	**36**	**37**	**37**	**36**
Ridgewood Lodge, Princeton	36	37	37	
Keremeos - R	**25**	**25**	**25**	**53**
Orchard Haven (SSHC), Keremeos	25	25	25	
South Okanagan	**196**	**178**	**178**	**242**
Sunnybank, Oliver	51	51	51	
McKinney Place, Oliver	75	75	75	
Sagebrush Lodge, Osoyoos	52	52	52	
Country Squire, Osoyoos	8	0	0	
Transition bed	10	0	0	
Total for Okanagan HSA	**2,382**	**2,090**	**2,301**	**2,704**

Regional Chronic Behaviour Disorder Unit				
Vernon	24	24	24	
Kelowna	20	20	20	
Total for IH	**44**	**44**	**44**	

Thompson Cariboo Shuswap HSA	Original Bed Numbers as at April 2002	Operating Current Approved Beds 2004 [1] [2]	Beds per 2004-07 HCC Service Plan [3]	Beds Needed 2009/10 Based on 75 Beds/1000 Pop. 75 +
Kamloops	**492**	**371**	**461**	**561**
Marjorie Willowby Hospice House, Kamloops	0	6	6	
Extendicare Pine Grove Lodge, Kamloops	75	75	75	
Liberty Manor/Overlander RC, Kamloops	200	190	190	
Royal Inland Hospital, Kamloops	25	0	0	
Ponderosa Lodge, Kamloops (respite)	192	0	6	
Kamloops Seniors Village, Kamloops *	0	100	100	
New Facility, Kamloops	0	0	84	
North Thompson - R	**0**	**21**	**21**	**20**
Dr Helmcken Memorial Hospital, Clearwater	0	21	21	
Lillooet - R	**22**	**22**	**22**	**21**
Mountainview Lodge, Lillooet	22	22	22	
South Cariboo - R	**24**	**21**	**25**	**44**
Ashcroft Hospital	14	21	25	
Lytton	10	0	0	
Merritt - R	**55**	**50**	**50**	**54**
Coquihalla, Merritt	30	25	25	
Gillis House, Merritt	25	25	25	
100 Mile House - R	**65**	**65**	**65**	**81**
Fisher Place (SCHC), 100 Mile House	39	39	39	
Mill Site Lodge (SCHC), 100 Mile House	26	26	26	
Cariboo-Chilcotin	**105**	**66**	**101**	**102**
Cariboo Lodge, Williams Lake	67	0	0	
Deni House, Williams Lake	38	0	0	
Williams Lake Seniors Village, Williams Lake *	0	66	66	
Hospice Palliative, Location to be determined		0	2	
New Facility, Williams Lake		0	33	
Revelstoke - R	**49**	**28**	**30**	**40**
Mt Cartier Court, Revelstoke	28	28	30	
Moberly Manor, Revelstoke	21	0	0	

[1] Excludes MH beds that may be on the site.

[2] Approved by Thompson Cariboo Shuswap Leadership Team June 2004 and revised Feb. 2005.

[3] The final planned beds resulting from the 2002-04 plan. Some bed numbers have changed as a result of the final outcome of renovations or operational plans. This column captures where IH will be once the current round of renovation, closures and new builds are complete. **They are not intended to capture the transitional changes in numbers as the plan is implemented.**

* Campus of Care

Thompson Cariboo Shuswap HSA	Original Bed Numbers as at April 2002	Operating Current Approved Beds 2004 [1 2]	Beds per 2004-07 HCC Service Plan [3]	Beds Needed 2009/10 Based on 75 Beds/1000 Pop. 75 +
Salmon Arm	~~207~~	~~176~~	~~227~~	~~268~~
Bastion Place, Salmon Arm	101	101	101	
Pioneer Lodge, Salmon Arm	75	0	0	
Hillside Village, Salmon Arm	0	75	75	
Fountainview, Salmon Arm	26	0	0	
SLGH	5	0	0	
New Facility, Salmon Arm		0	51	
TOTAL for TCS HSA	**1,019**	**820**	**1,002**	**1,191**

Total for Interior Health	**4,708**	**3,834**	**4,250**	**4,870**

Interior Health

Appendix F

Assisted Living Sites - HCCR Plan 2002 to Final Allocation

Thompson Cariboo Shuswap	Units in Place Prior to 2002	Unit Allocation as per HCCR Plan 2002	Opened 2003-04	Opening 2004-05	Opening 2005-06	Final Allocation
Kamloops		83			76	76
Chase			20			20
Barriere		3			8	8
Ashcroft		7			8	8
Lytton					6	6
Lillooet		3			6	6
Merritt		9		7		7
100 Mile House		15	12			12
Williams Lake		16		15		15
Salmon Arm		39			30	30
Revelstoke		6			11	11
Totals		**181**	**32**	**22**	**145**	**199**
Okanagan	**Units in Place Prior to 2002**	**Unit Allocation as per HCCR Plan 2002**	**Opened 2003-04**	**Opening 2004-05**	**Opening 2005-06**	**Final Allocation**
Lake Country		171			25	25
Westbank					40	40
Kelowna					52	52
Kelowna - Sun Pointe	20					20
Kelowna Mountain View			37			37
Kelowna Joseph Benjamin				38		38
Penticton		58		30		30
Penticton Village By the Station				35		35
Summerland		18		18		18
Keremeos		7		13		13
Princeton [1]		6				
Oliver/Osoyoos		33	33			33
Vernon		64			38	38
Vernon - Heritage Square				23		23
Armstrong - Pioneer Square		9		20		20
Enderby [2]		8				
Totals	**20**	**374**	**70**	**177**	**155**	**422**
Kootenay Boundary	**Units in Place Prior to 2002**	**Unit Allocation as per HCCR Plan 2002**	**Opened 2003-04**	**Opening 2004-05**	**Opening 2005-06**	**Final Allocation**
Nakusp		6		8		8
Grand Forks		17		17		17
Castlegar		13	15			15
Nelson		27		29		29
Trail		24		26		26
Totals		**87**	**15**	**80**	**0**	**95**
East Kootenay	**Units in Place Prior to 2002**	**Unit Allocation as per HCCR Plan 2002**	**Opened 2003-04**	**Opening 2004-05**	**Opening 2005-06**	**Final Allocation**
Fernie		10		10		10
Cranbrook		22	25			25
Kimberly		10		11		11
Invermere		8		8		8
Creston		19			21	21
Golden		5			8	8
Totals		**74**	**25**	**29**	**29**	**83**
IH Totals	**20**	**716**	**142**	**308**	**329**	**799**

[1] Units were combined with Keremeos

[2] Units were combined with Armstrong

Prepared by: Home and Community Care Planning and Development
Assisted Living\Project Tracking\AL 2002 Plan to Final - Updated with additional units May 05/3/2005

Appendix G: Complementary Reports

The following complementary reports are available on the Interior Health website: www.interiorhealth.ca

Population Health Profile 2004

Health Services Report

Health Service Area Profiles/Local Health Area Profiles 2004

Health Service Area/Local Health Area Status Vignettes 2004

Health Services and Budget Management Plan 2004/05 – 2006/07

Preliminary Analysis of the Canadian Community Health Survey

Chronic Disease Management Plan June 2004

Rural Health Services Planning Framework

Strategic Development Plan for Mental Health

Aboriginal Health Plan

Appendix H: Glossary of Terms

ABI	Acquired Brain Injury
AIM	Achieving Improved Measurement
AL	Assisted Living
ALC	Alternative Level of Care
BC Housing	A provincial crown agency that develops, manages and administers a wide range of subsidized housing options across the province
CCIMS	Community Care Information Management System
EK	East Kootenay
EOI	Expression of Interest
HC	Home Care
HCC	Home & Community Care
HSA	Health Service Area
HSCL	Health Services for Community Living
IH	Interior Health
ILBC	Independent Living BC The province, through BC Housing, is facilitating the Independent Living BC program in partnership with the federal government, regional health authorities, and the private and non-profit sectors. The program will create 3,500 affordable independent living units with support services across the province by 2006.
KB	Kootenay Boundary
LHA	Local Health Area
LTC	Long Term Care
MCFD	Ministry of Children & Family Development
MOHS	Ministry of Health Services
OK	Okanagan
PCI	Patient Care Inquiry
RC	Residential Care
RFP	Request for Proposal
TCS	Thompson Cariboo Shuswap